PROPOSALS FOR NATIONAL SOLUTIONS: ANOTHER PERSPECTIVE*

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THE problems involved in improving access to care are complex. There are no ready or easy answers. But the outline of approaches to the solutions which the administration in Washington is proposing, and which you have just heard described, do not give this observer grounds for feeling encouraged. They remind me of the story of Dr. Samuel Johnson, who a long time ago was persuaded to review a manuscript which he did not want to read. He finally wrote to the author and said, "Dear Sir: I have read your manuscript and must say that it is both original and good. Unfortunately, however, that part which is good is not original, and that part which is original is not good."

While government and the private sector have struggled with trying to contain runaway inflation in the cost of health services, problems of access of some 45 million people to decent health care programs have been shunted aside, the malfunctioning of an outmoded delivery system neglected, and efforts to improve the quality of care disregarded. Priority is being given to costs, to prices, to numbers instead of to people, their health, and their well-being. American workers, who, during all their years of employment, have paid payroll taxes in the belief they will get decent levels of health care protection when they retire now hear new words like the need to slash entitlement programs, and the contributions they should be making to increased expenditures for arms, and to the reductions in taxes for the well-to-do.

Medicare is rapidly becoming a second class health insurance system on the way to becoming third class. At the same time, the percentage of income the elderly and the severely disabled are paying for their health care is only about 1% less than it was before Medicare became a law. The

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well-being of our society is being eroded by over 10 million Americans who are unable to find work. Unless they go on public welfare, most of them have no health protection for themselves and their families. Have you heard any discussion about these new casualties and their lack of medical protection? And what happens to them when their incapacities and illnesses no longer enable them to continue to work or to return to work?

The administration's approach to the high cost of health services has not been to contain costs but to slash services and entitlements. Having already cut $2 billion a year for each of the next three years from Medicare and Medicaid, they propose to slash some $5 billion more in this fiscal year. This misguided focus will not save money, for if health protection is diminished and health services eroded, the price the American people will pay is far greater than dollars saved on a annual budget statement. They will pay it with sicker children and adults, more illnesses that could have been prevented, and more costs of long-term care for conditions which earlier treatment might have prevented.

We heard reference a few minutes ago to the Rand study. Let me refer you to a study of 23 million people conducted in Canada. It has had a 15-year history of government-assured comprehensive health care with first dollar coverage and what was described this morning as "free care." It is interesting that when Canada began its program, costs were 6.6% of the gross national product; our costs were 6.6%. Canada now covers everyone; we still have 45 million people not covered. And their costs have reached 7.1% of the gross national product, and have leveled off over the last five years. Ours keep going up and up and up, and currently run at about 10% of the gross national product. Is there any lesson to be learned from this experience with 23 million people? Or should public policy decisions arise from a study which reaches conclusions on cellular units as small as 110 people?

The evidence in Canada was best summed up by Mr. Supreme Court Justice Hall who, as a special commissioner, chaired a Royal Commission which conducted a year-long study in 1980 of the entire health system, which has all these terrible things, like comprehensive benefits, no deductibles, and no co-pays and "free care." The conclusion of the report is as follows, and I quote. "I found no one, not any government, not any individual, not the medical profession, or any organization not in favor of the national health care system." Today the national health insurance plan is rated the most popular of the public services.

The political climate in this country is such that it is not likely that a comprehensive national health insurance program can be passed at an early date. However, the right of all Americans to access to decent health care will and must continue to be a goal toward which we strive. In the present context of our country, it is possible to deal with the major problem of runaway health care costs in a far more constructive manner than that proposed by the present administration in Washington and some of its supporters in Congres. These cost-containment proposals—which we call Reagamedics—take several forms: so-called competition health insurance plans; tax ceilings on employees, employers or both, which would penalize those seeking comprehensive health insurance protection; and so-called medical vouchers, particularly for the elderly and the severely disabled who would be given an opportunity to substitute them for Medicare.

All these plans of the administration have three things in common: Shifting a substantial portion of public program costs to private health insurers, thus transferring more of the costs of public and private health insurance to patients and other consumers; decreasing the cost of public personal health programs by reducing the numbers of eligible persons and decreasing benefits (1.1 million people lost Medicaid coverage last year); mandating economic deterrants to early diagnosis and treatment of health problems.

These proposals will not save money. They will cost more. The health professionals in this room understand that we are not talking about treating the common cold. We're talking about undetected or untreated hypertension, which will cause strokes, heart attacks, and eventual death. Delayed prenatal care results in more maternal deaths and more babies who die prematurely or are born with birth defects. When the health clinic in Mound Bayou, Mississippi, was required to introduce co-payments for the poor people who were their patients, they had a 40 % drop in outpatient visits; 20 % of those were infants less than 12 months of age.

Emotional problems neglected by lack of outpatient care end up as long-term institutional patients; and the splendid network of nonprofit, community and teaching hospitals and community health centers, built over many years in this country, is in serious danger of crumbling under the weight of increased demand from larger numbers of sicker patients; and fewer of them are able to pay for needed medical service.

It is possible at this time to adopt a health care cost-containment plan that would really contain costs, not slash services, not give money

penalties to restrain patient use of services, or transfer expenditures to the private sector, as has in fact been happening at an increasing rate. Such a program could and should have as a principal focus the protection of patients and the quality of personal health services the patients receive. This can be done in an effective cost-containment system. It could also assure protection for the health care workers and for the capital debts of health care institutions whose programs need to be changed by new organization and arrangements.

The Health Security Action Council, based on the work of a very competent technical committee which has worked on this for some time, has announced a program designed to contain costs, to save as much money as the administration proposes to save, but not to save it at the expense of the patient, as a constructive alternative. Presently, the administration proposes cuts in practically all health services programs. We organize, we prepare papers, we line up arguments in opposition. And if we are successful, as we sometimes are, we succeed in defeating, or at least reducing, some of the administration proposals. But when we add it up at the end of the session, as we did last year, we realize that with all our victories most of the administration program reductions remained.

The program we propose would put an immediate brake on health cost escalation, while a new series of state controls, based on prospective budgets and negotiated agreements with providers, insurers, and other payors are put into place. The new plan, we estimate, will save $5 billion in public expenditures in each of the first two years of operation. Of these savings, some $1.5 billion would be returned each year to the states as incentive payments under Medicaid. The private sector would also benefit. It would be expected to spend annually some $7 billion less, without reducing benefits, under this plan than if the administration's proposals were adopted.

The new program can effectively begin to produce needed system changes and at the same time protect the consumer. It has three principal features: Comprehensive cost-containment across the entire system, public and private, including hospitals, nursing homes, and professional providers of health services. State responsibility and flexibility in the cost control process, combined with prospective budgeting with ceilings on hospital and nursing home payments, based on the previous year's expenditures, plus increases allowed for the rate of inflation in the economy.

During the first two years of the plan, the state ceiling would be set by the state in accordance with previously defined principles. This would

almost cut in half the rate of escalation of health costs, and would assure the continuation of present benefits and entitlements of public programs without the kinds of slashes that have been proposed.

Hospitals. The principle feature of the program would be a state prospective budgeting system with annual ceilings for both hospitals and nursing homes. Together, they constitute almost half the current payments for personal health services. The total budget for state expenditures for hospitals, public and private, but excluding state mental hospitals, would be based on the previous year's total expenditures, or a typical year during the last three years, or the average of the last three years' expenditures. This would be adjusted by the increase in the consumer price index for the past year. The percentage increase allowed would be uniform for both public and private sector costs and/or reimbursement. Federal and state governments would continue to receive discounts which derive from their position as the major purchasers of hospital services.

Each of the principal payers for hospital care, including Medicare and Medicaid, would be limited in its payments by its previous proportion of hospital care payments to total state spending for hospital care. Annual adjustments would be made for such factors as the number of persons enrolled, their age, and their health status. Federal Medicare and Medicaid funds would provide the leverage for the new system in each state. The law would require, however, that private insurance payments be included in the state programs, a phenomenon not unknown in this state.

Medicare would continue as a federal program with full control of eligibility and benefits and, through intermediaries, would continue to monitor program operation to assure the proper implementation of federal law and policy.

The key to cost control, however, would be the states. They are closer to the actual delivery systems and in a better position to see that a control plan works. The states could, as long as they remained within predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways: prospective budgeting by category of hospital; formulas to set limits on what would be charged to various payers; budget reviews of each hospital; capitation payments for defined populations. There is to be the widest flexibility as long as the state stays within the guidelines and the ceiling.

A state agency, either responsible to the government directly or as a semiautonomous unit in the health department, would manage the program and be responsible for negotiations with hospitals and insurers and would

provide for adequate consumer representation. Savings from the negotiated budget would be shared by hospitals, the public, and the private payers.

States which participate in the program would have the incentive of an approximately 10 % reduction in their contributions of Medicaid funds in the following year. These reductions would be financed from the reimbursement savings engendered by the operation of this plan. Since in all likelihood it would take a year or more to make the plan operative, hospitals would be required to operate for 24 months under a fixed reimbursement formula, adjusted for inflation as described earlier. The federal government would be authorized to operate the program in any state that did not elect to participate in the program.

The same approach would apply to nursing homes and intermediate care facilities. But here we enter the caveat that there would have to be special provisions for monitoring to assure maintenance of quality standards. We question whether present licensing requirements assure adequate protection for the quality of care. And, with these new controls, it would be necessary to have additional monitoring available for this purpose.

Physicians and other providers. Existing reimbursement methods inflate health care costs by encouraging procedures and discriminating against services that do not involve technology. They fuel the cost increases. Under the health care cost-containment plan, third party payers, including state insurance companies and third party intermediaries, organized labor, and representatives of the public, along with physicians, would negotiate annual fee schedules or alternative payment arrangements that would be used for reimbursement. Initially, these schedules would be set at present levels in each of the three programs in the state: Medicare, Medicaid, and private insurance. A single level fee schedule is obviously preferable, but would probably be too costly to public programs in the initial and transition stages. Hopefully, over time we could move to that.

Incentives would be built into the payment structure to encourage primary care, disease prevention, and health promotion and to provide appropriate compensation for treatments which are time and process oriented. The health care cost-containment plan would mandate "assignment" for in-hospital and nursing home services provided by physicians and other professional providers. Since it would in all likelihood take a year or more to make the health provider cost-containment plan fully operative, states would be authorized to ban increased rates of reimbursement for physician and professional providers for a 24-month maximum period, except for an allowance for increased overhead costs, reflecting inflation rates.

Laboratory and radiology services. Each state would appoint a laboratory and radiology payment committee under the health care cost-containment agency. It would be composed of representatives of the public agency, Medicare, providers, insurance companies, consumers, and the laboratory and radiology providers themselves. Fee schedules would be developed annually and payments made on this basis, through a negotiation process.

Health Maintenance Organizations. Separate contracts would be negotiated, offering them maximum reimbursement, up to the prevailing costs in the area adjusted by age and health status. I've never understood this business of "We'll give them 95 % of what others get." Why should they receive less if they provide more services? The objective would be to avoid selective enrollment of favorable risks. Unions, employers, and insurers would be encouraged to organize new health maintenance organizations. This is urgently needed because the government subsidy program for the new nonprofit organizations has been scrapped.

Partial tax forgiveness for employers up to a stipulated maximum of first-year organizing costs of new nonprofit Health Maintenance Organizations would be provided through a provision for a write-off as a business expense or payment of an extra 5% in premiums in each of the first three years of operation.

New technology. An essential part of the plan calls for setting up a national program on new procedures and new technology. You recall the new Center for Health Technology was just getting under way when it was scrapped during the battle of the budget of 1981. It was beginning to carry out important work in evaluating new procedures and new technology and advising the professions, the insurers, and the consumers. We suggest that if it is not accepted at the governmental level, such a program be organized under the Institute of Medicine of the National Academy of Sciences. It would give regular advice to the profession, to insurers, and to consumers on the new technology which is important and which is sometimes highly valuable and is sometimes of no value. It is very difficult for the average physician, the average hospital, and certainly the average consumer to know which is which.

Long-term care is a problem, and we suggest that efforts be made to respond to the need to encourage, on a demonstration basis, the development of "social Health Maintenance Organizations" or "personal care organizations," and to authorize use of Title XX money and Medicaid funds in demonstration, to attempt to encourage the development of more

humane as well as more cost-effective alternatives to institutional care.

So where are we at this point? This plan is realistic and achievable within a reasonably short time. We are now having the legislation drafted. We hope to have it introduced shortly. It would take courage on the part of the Congress to initiate it, for it indeed represents a fresh approach to dealing with the escalation of the costs of health care. And I hope it is clear that it is a constructive alternative to the plans that you heard discussed.

These are the results that are possible. Savings in the budget expenditures for Medicare, Medicaid, and personal health services would be comparable to those proposed by the Reagan administration, but achieved without drastic reductions in eligibility and benefits. Relief to the states in their constantly increasing expenditures for Medicaid programs without further reducing eligibility for benefits would begin. Some 7 billion dollars would be saved in the private sector per year. States would regain needed initiative and authority to control costs in their own jurisdiction, but without change in the national structure of the Medicare program. And cost shifting from federal programs to the private sector, to states and to patients would halt while maintaining adequate protection for health care workers.

Finally, it would begin an altered way to provide for the delivery of health services and the containment of costs that could lead to true reform that would protect patients and would be concerned not only about dollars, but about people.

The principal drawback to this alternative plan is that, because of the budgetary situation in the Congress, it does not presently appear possible to provide for improved access to health care for many who need it. Nor does it make possible desirable augmented health benefits.

It is, however, the first constructive efforts to deal with what I call Reagamedics or the 1982 radicalization of health care. I call it that because, as one looks over the history of the countries involved in the industrial revolution, each made decisions to create social programs and institutions to deal with the problems associated with the changes in life style created by industrialization.

The threats to health were identified rather early. Beginning in the late 19th century, practically every industrialized or semi-industrialized country recognized the need for increased public responsibilty for safeguarding the health of its citizens. Sixty-one countries responded with national health insurance or national health service programs. Two, the United

States and South Africa, went other routes. The American response has been through a combination of major government support for scientific research and subsidy of professional education to put in place the potentials for a splendid health care system. But payment for the delivery of the services was to be accomplished through a combination of private insurance and public programs. As you are aware, this latter part has not worked well. In piecemeal fashion the United States has been trying to improve its patchwork of health programs.

In 1981 a new administration called a halt. Rather than to reform or to attempt to improve, they are essentially turning back the clock. They are cutting back public responsibility, reducing the federal role, and proposing programs that on the one hand shift expenditures to the private sector, and on the other encourage the private sector to shift more of the costs and responsibilities to the individual patient.

Our role is to see the administration proposals for what they are and to protect the patient from discredited nostrums.